National Disability Insurance Scheme (NDIS) Costs - Productivity Commission Position Paper

Introduction

CMHA would like to thank the Productivity Commission (the Commission) for the opportunity to make a submission to the National Disability Insurance Scheme (NDIS) Costs Position Paper.

CMHA would like to commend the Commission on the Position Paper, which has made a number of recommendations addressing the issues raised by the community managed mental health sector, including through CMHA's submission to the Commission's Issues Paper. The Commission's acknowledgement of the seriousness of issues around implementation and the planning process and that people with psychosocial disability are being disproportionately impacted is an important step and addressing these significant issue.

While the Federal Government and the National Disability Insurance Agency (NDIA) has also acknowledged that there is significant improvements to be made, CMHA are concerned that the problems are being characterised as 'hiccups' or 'teething' problems, which does not recognise the gravity of the problems which risk becoming systemic if not urgently addressed.

The Position Paper notes in the section about the Commission's approach and the challenges of the NDIS, that the Commission's 2011 report on establishing the NDIS recommended that the trials start later than they did and that aspects of the NDIS were being built and tested over the trial period. This situation continues now at the implementation stage where key pieces of work, such as a functional assessment tool and reference packages for psychosocial disability, for example, have not been finalised.

CMHA recognises that there are different views regarding the timeframe for rolling out the NDIS, and that people do not want to delay receiving any benefits that the NDIS can deliver. CMHA agrees that people should receive the benefits of the NDIS. CMHA also believes that key processes should be well established and systemic problems addressed so that that people with psychosocial disability are not adversely impacted because this has not occurred. This must be taken into account in determining the timeframe for the ongoing implementation of the NDIS.

It is also vital that the advice the NDIA and the NDIS Board are receiving through the formal structures of the Independent Advisory Council (IAC) and the Expert Advisers, is representative of the disability sectors and groups, in particular those that are experiencing the most challenges with the NDIS, as has been identified by the Commission in the Position Paper. The Commission has highlighted the issues occurring for psychosocial disability and that people living with psychosocial disability are one of the groups experiencing the worst outcomes. We also know through the available data and anecdotally that Aboriginal and Torres Strait islander people are the least engaged in the NDIS and experiencing particular challenges. It is vital that the formal structures advising the NDIS process reflects this diversity and the associated challenges, which currently it does not, including through additional appointments announced on 27 June 2017.

CMHA's submission to the Position Paper will address the key sections, recommendations and requests for further information from the Commission.

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Psychosocial disability and the NDIS

The Commission has stated that while concerns were raised about the need for permanency under the NDIS Act being incompatible with recovery models used in supporting people with psychosocial disability, the Commission did not support changing the eligibility criteria to relax the definition of permanency and how it relates to psychosocial disability.

CMHA, Mental Health Australia and Mental Illness Fellowship Australia (MIFA) submitted a supplementary submission to the *Joint Standing Committee on the NDIS inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition. The* This argued for the need to change the NDIS Act and replace the word 'permanent' with 'ongoing, enduring or chronic'. The supplementary submission also recommended other amendments to section 24 of the NDIS Act:

- Remove references to *psychiatric condition* and replace with *psychosocial disability.*
- Consider incorporating into 24.1 (b): *the impairment or impairments are ongoing, or likely to be ongoing without the person receiving supports intended to build their capacity.*
- Use of a validated assessment tool, a full assessment of a person's functional capacity to undertake activities of daily living can preclude the current requirement that a *psychiatric condition* be demonstrated by medical certification.

CMHA subsequently note that the American Psychiatric Association DSM V recommends use of the World Heal Organisation Disability Assessment Scale (WHODAS 2)[1]. However, the NDIA Independent Advisory Council (IAC) says that WHODAS 2 does not identify the level or type of support assistance required.[2] The IAC recommend that the NDIA explore the development of a validated Australian instrument based on ICF WHO's International Classification of Functioning, Disability and Health (ICF)/WHODAS for determining severity of functional impairments and support needs of people with psychosocial disability. Such an instrument would provide the NDIA and the mental health sector with clearer guidance and a validated tool for the assessment of functional impairment.

The IAC believes that such an instrument may also contribute to the financial sustainability of the NDIS. Such an instrument could reduce review costs and provide assessments that are more consistent. Some of the leading world experts on ICF and WHODAS are in Australia and have the knowledge and capacity to develop an appropriate instrument.

CMHA would ask that the Commission consider these recommendations regarding the use of the term permanency and apply wording, which better reflects the range of disability groups who will receive assistance through the NDIS. . The NDIS also needs reliable processes for assessing and costing people's functional and participation support needs, and objectively measuring changes to a person's capacity.

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[1] Kress, V. et. al. (2014). *The Removal of the Multiaxial System in the DSM-5: Implications and Practice Suggestions for Counselors.* The Professional Counselor Journal. 4 (3): 191–201: http://tpcjournal.nbcc.org/wp-content/uploads/2014/07/Pages-191-201-Kress.pdf

[2] NDIS Independent Advisory Council (2015). *IAC Advice on Implementing the NDIS for People with Mental Health Issues*: https://www.ndis.gov.au/about-us/governance/IAC/iac-advice-mental-health.html

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Scheme Supports and plans

Scope of supports

The Position Paper discusses issues around the concept of 'reasonable and necessary', and that this is not defined in the NDIS Act and does not provide guidance on how to determine whether a support is reasonable and necessary. The Position Paper states that this allows flexibility and innovation for choice and control. It also states that this is a policy lever outside the control of the NDIA and that what is 'reasonable and necessary' would be shaped by court and tribunal decisions.

CMHA would argue that not having a clear understanding of what is reasonable and necessary is a significant cause of many of the problems occurring with the NDIS, in that what the NDIA considers as reasonable and necessary may be very different to what a consumer considers this to be. The lack of a clear understanding is leading to a range of different interpretations, which inevitably impacts on the types and consistency of plans being approved. The lack of clarity around reasonable and necessary where the only avenue for appeal is intimidating and onerous creates a power imbalance in the system where the NDIA become the expert and the participant becomes a recipient. This reflects a welfare system rather than an entitlement system.

CMHA's submission to the Issues Paper stated that the use or interpretation of the NDIS Act 2013 by the NDIA appears to be an area requiring examination. The December 2015 independent review of the NDIS legislation by Ernst and Young[3] stated as a key finding that while, at the time, the legislative framework was broadly enabling government to progress the NDIS Act, an important caveat was that the NDIS was at an early stage and evolving. That as the scheme moved into more locations and took on more people, a key recommendation was the government should conduct another review in 2 to 3 years to ensure the legislation was 'fit for purpose' for full scheme. CMHA would again recommend that the NDIS Act must be reviewed now that the legislation is actually at implementation, as recommended by Ernst and Young's 2015 review of the NDIS legislation.

A process of relying on NDIS participants having to take cases to a tribunal or a court when what they think is reasonable and necessary is different to the NDIA's is not how the scheme should be undertaken. Relying on a process that is costly, not timely and likely to cause stress to the individuals involved is far from ideal and not sustainable. The NDIA may appeal any court or tribunal decisions, as occurred in the instance of a court case around transport costs, which does nothing to engender a workable and trustworthy relationship between the NDIA and NDIS clients. The current issues around what is reasonable and necessary is not leading to flexibility and choice and control, and appears to be guided by a cost driver rather than delivering quality care that is best for the NDIS participant.

The Government tabled amendments to the NDIS Act on 27 June 2017 inserting the word 'sustainable' around people accessing innovation etc. to have a 'normal 'life'. The changes amend the principle in subsection 4(15) of the NDIS Act to directly refer to a diverse and sustainable market and sector in which innovation, quality, continuous improvement, contemporary best practice and effectiveness in the provision of those supports is promoted. While these amendments would seem appropriate on face value, the significant issues that are occurring around what is 'reasonable and necessary' would mean

[3] Ernst and Young, Independent review of the NDIS Act, December 2015, https://www.dss.gov.au/sites/default/files/documents/04_2016/independent_review_of_the_ndis_act.pdf

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that the addition of further words that focus on sustainability may cause further complications if the main driver is a cost factor. This again points to the need for a proper examination of the legislation, as in the absence of this, amendments will be proposed and potentially made to the NDIS Act that have not been fully considered and potentially impact on what type of support a person can access within the scope of what the NDIA considers is appropriate.

About plans and the planning process

The Position Paper notes that good planning processes are essential for the long-term sustainability of the NDIS and lists a number of consequences of poor planning, primarily relating to the costs of the scheme, comprised equity, and stress on the review process and the NDIA. What this does not recognise is a point the mental health sector is continually asking all involved in the implementation to recognise, is the undue stress and distress the problems with the planning process are causing to consumers and carers and the quality of care they receive and the sector is able to provide. The point of quality is getting lost in the focus on 'costs', as is the lack of expertise in the NDIA planning processes which is also a cause of inappropriate plans.

The Position Paper makes the point a number of times that the NDIS is not a welfare system, and CMHA has been pushing for the recovery approach that the community managed mental health sector applies to be a focus on the NDIS. However, while it is not a 'welfare' system, it is about the long-term welfare of highly complex individuals and again this seems to be getting lost in the focus on how to manage the costs of the scheme.

A consequence of poor planning also noted is that participants are allocated inappropriate support with the result that the benefits of the NDIS are not realised. This would again point to the need for a proper consideration and legislative review including of what is determined as reasonable and necessary, and not leaving this to legal processes initiated by participants.

Regarding the statement "Participants with psychosocial disability, and those who struggle to navigate the scheme, are most at risk of experiencing poor outcomes", the Mental Health Council of Tasmania (MHCT) has found in its consultations with members that this is the case. In their Submission to the Joint Standing Committee on the NDIS inquiry into mental health, MHCT noted that, due largely to a "lack of a standard approach, catering specifically for psychosocial disability, the planning process seems to be conducted on a case by case basis. This has led to some less than optimal outcomes, for example we have heard anecdotally that those people who can better put their case are often receiving large packages even where they do not need such a high level of support, while others, who clearly need more support, are receiving minimal packages because they cannot articulate their needs or provide a convincing argument."[4]

Similarly, in Victoria, the Psychiatric Disability Services of Victoria (VICSERV) were provided funding by the Victorian Government to engage and provide support to service providers during the transition to the NDIS. Whilst undertaking this work in the Barwon region, which has now experienced full roll-out of the NDIS, VICSERV noted a direct relationship between how much time and resources are dedicated to

[4] Mental Health Council of Tasmania (2017), Submission to the Joint Standing Committee on the National Disability Insurance Scheme, pp.1-2, http://www.mhct.org/wp-content/uploads/2017/02/MHCT-Submission-to-Joint-Standing-Committee-on-NDIS-.pdf

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preparing a client (including sourcing and compiling paperwork and reports) and how likely they are to be deemed eligible for a funding package – and the quality of the subsequent supports in their plan. One service provider reported that this pre-engagement support was attributable to 20 hours of work per client.

With regards to phone planning conversations, CMHA is pleased to have seem the Commission listen to the concerns raised and recognise that this is a process that will not be appropriate for some participants, in particular people with mental illness, cognitive impairment, and people from Culturally and Linguistically Diverse backgrounds. Aboriginal and Torres Strait Islander people must also be included in this recognition, as was noted in CMHA's submission to the Issues Paper.

The point made in the Position Paper that phone planning may be 'adequate' for others if there has been 'adequate' pre-planning, must have the provision that this is only if the participant has requested phone planning and that it is not a blanket approach applied in any location. The Issues Paper notes that an individualised approach to planning is the key feature of the NDIS, and this principle must apply to all participants so that they receive quality care that is actually their choice.

A proper pre-planning process – as CMHA has recommended and outlined in the Issues Paper submission – would improve any further or follow-up processes, but it still should be about what the person requests the planning process they need. This goes to people being able to understand the planning process and what their plan will provide them, and language difficulties, cognitive impairment and mental health conditions will all affect a participant's ability to fully engage.

The recommendation on pre-planning could go further to allay the concerns of services, consumers and carers. Consultations undertaken to inform a recently released joint report by Mental Health Australia and the NDIA stressed the importance of engaging consumers and carers on their terms and in a manner appropriate to their distinctive circumstances. The consultations highlighted that the majority of NDIS participants with psychosocial disability will have had minimal experience with choice and control.[5] Accordingly, significant support may be required to assist a participant to prepare for their first planning meeting. For people with psychosocial disability, a short planning session will for the most part not be enough and the whole process from preplanning to completed plan can take several months to resolve.

Planners need more disability knowledge

CMHA fully supports the Commission's recommendations in the Position Paper that planners should have, at a minimum, general understanding about different types of disability, and particularly specialised planning teams for psychosocial disability. The knowledge and expertise of planners in mental health was raised in CMHA's submission to the Issues Paper and it was recommended that planning must be conducted by people with experience in and an understanding of mental health and culturally relevant factors.

The Commission identifies one approach to providing expertise could be to leverage expertise from specialist disability organisations or service providers more involved in the planning process, noting any conflict of interest issues would need to be addressed. CMHA has reinforced through a number of forums the need for the NDIA and Local Area Coordinators (LACs) to engage with service providers,

[5] National Disability Insurance Agency and Mental Health Australia, *Psychosocial Supports Design Project – Final Report*, 2016, p 17

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particularly in the community mental health sector, as they will well know participants in their area and will also be best placed to provide the necessary expertise. The community managed mental health sector would be well placed to engage through this process in relation to psychosocial disability.

An approach to consider could be similar to that applied by the Western Australian Planning Alliance and adopted by NDIA in WA. This was to identify key community managed mental health organisations and subcontract them to write plans, or to consider subcontracting community managed mental health organisations as LACs and have them complete planning.

Information Request 4.1

As noted above in 'Scope of supports'.

The MHCT has noted that consumers and carers need to be fully aware of their rights in terms of support and what the parameters of support may be. Based consultations, MHCT are not convinced that consumers and their carers find this criterion sufficiently clear and need to be better supported to understand what "clear and reasonable" really means for the purposes of developing individual plans.

Information request 4.2

The NDIA should only delegate the LAC plan approval functions where it is clearly determined that there is the capacity and ability to do this both in terms of the numbers of staff and the expertise to undertake planning for different disabilities. The same requirement for expertise within the NDIA has recommended by the Commission, particularly in relation to psychosocial disability, would need to be a definite requirement. Shifting responsibility from one part of the NDIS to another will have no change or impact if the same problems around expertise aren't addressed. Some of the organisations to have been the successful LAC tenderers do not have expertise in any area of disability, therefore this would have to be addressed. As noted, the requirement for expertise with the NDIA must also apply to LACs.

The principles and practice of recovery oriented service provision must ground service provision to people with psychosocial disability if they are to benefit from the NDIS. This means there will be a need for funding to increase the number, and quality and effectiveness, of LACs.

In the Partners in Recovery (PIR) Tasmania Consortium submission to the Joint Standing Committee on the NDIS, it was proposed that a specific mental health 'stream' working within the recovery model could be set up and could involve "the creation of a specific psychosocial gateway service for people with a psychosocial disability that converts the concepts of permanent disability to a system that supports recovery. Practically, this may include NDIA Community Engagement staff and LACs who are specifically trained in understanding the needs of mental health consumers and appropriate service responses within the recovery model, to ensure engagement, planning and reviews are timely and relevant for participants."[6]

Boundaries and interfaces – the NDIS and services outside of the scheme

CMHA supports the point made by the Commission in the Position Paper that the NDIS was not expected to fill all service gaps. We also do not want to create a situation where some people receive a

[6] Partners in Recovery Tasmania Consortium (2017), Submission to the Joint Standing Committee on the National Disability Insurance Scheme p. 13, https://www.anglicare-tas.org.au/sites/default/files/PIR%20Tasmania%20Submission%20FINAL.pdf

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high level of support and others do not. People living with a mental health condition must have their psychosocial needs met regardless of whether they are eligible for the NDIS or not. The NDIS was never meant to and cannot replace the mental health system.

As CMHA stated in the submission to the Issues paper, the interface between the NDIS and mainstream services and the gaps that will be created for mental health in the transition to the NDIS are some of the most significant and concerning issues for the community-managed mental health sector.

A range of highly successful community managed mental health services will no longer be funded in various jurisdictions as the NDIS moves to full implementation. These services are primarily focused on community-based rehabilitation and their disappearance means that people will no longer have access to these services that help them to reduce the disabling impacts of their mental illness. This has consequent issues in relation to the NDIS such as the potential for a growing level of disability over time of people entering the scheme, as well as the appropriateness of the pricing structure and its relationship to qualified mental health staffing being able to provide effective rehabilitation services, and therefore the level of funding provided to mental health NDIS packages.

CMHA agrees with the recommendation of the Commission in the Position Paper that until the interface issues and associated boundaries are settled, it is important that governments do no withdraw from services too quickly. This points to the significant issue of the gap in service provision that will be created with the transferring of funds for federally funded mental health programs from the Department of Health (DoH) and Department of Social Services (DSS) for Partners in Recovery (PIR), Day to Day Living (D2DL), Personal Helpers and Mentors (PhaMs) and Mental Health Carers: Respite Support service to the NDIS whilst many of the people currently receiving assistance from the funding will be ineligible for the NDIS.

CMHA's submission to the Issues Paper recommended that the Department of Health must continue to fund a low barrier to entry, flexible program for people living with a mental illness who will not be eligible for the NDIS. The Federal Budget 2017-18 announced $80 million funding for community-based mental health, with the requirement that it be matched by each state and territory, to address the gap in services for people with a psychosocial created by the NDIS. This funding will go some way to addressing the gap, however there has been no sector-wide evaluation of the estimated number of people with psychosocial disability currently in federally funded programs who won't be eligible for the NDIS, and a low barrier to entry, flexible service will still be needed.

A further interface issue is the crossover between disability and chronic health issues, which people with a mental illness are over-represented in when it comes to such co-morbidities. The proposed amendments to the NDIS Act tabled in the Parliament on 27 June 2017 propose inserting words around 'support that a person is likely to require must be appropriately funded or provided through the NDIS and not more appropriately funded or provided through the NDIS and not more appropriately funded or provided through other mainstream general systems of service delivery or supports such as health or education'. The Explanatory Statement to the amendments states that this relates to chronic illness. CMHA raised this at the NDIA CEO Forum and it was also raised in Senate Budget Estimates. This is an issue needing much further discussion and CMHA has concerns about how this may then be interpreted.

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An issue which CMHA believes requires considerable examination before any changes to the Act around where supports are accessed is considered, is what funding states and territories have transferred to the NDIS that provided chronic disease support for people with disability. Attached separately to this submission is a case study from Queensland which concerns a person with complex mental illness and chronic diabetes who received support to manage the diabetes and administer insulin. This funding for this support was transferred to the NDIS. The person was found eligible for the NDIS but was informed they would need to access support for the diabetes through state health services, despite the fact that the support they were receiving previously was now with the responsibility of the NDIS. As the letter points out, the crucial point is that the person's mental illness means they cannot look after their diabetes, therefore the disability and the chronic illness cannot be separated.

CMHA corresponded with the Minister for Social Services office regarding the concerns and was informed that the proposed changes to the *NDIS Act* have been agreed by COAG and are supported by the NDIA and all state and territory Disability Ministers through the Disability Reform Council. There would presumably be other similar cases of funding for chronic health and disability support being transferred to the NDIS. It reinforces the point of the Commission that governments do not withdraw from services until interface issues are resolved.

There must also be ways of providing coordinated support to people with psychosocial disability and co-morbidity, such as chronic illness, who are NDIS participants without them having to go to more than one service system. Coordinated, wrap-around support – regardless of what the support needs are – is the crucial part of a psychosocial approach to addressing mental illness and this will be lost if people are forced to seek help in more than one service system, many of whom are not able to do this. The Federal Government and the State and Territory Governments must be able to determine with confidence where there is service crossover, and come to payment arrangements where that is required, so that NDIS participants receive the support they need through one package. CMHA's members have identified this as a real and relevant issue.

CMHA agrees with the point made by the Commission that with the agreement between the Commonwealth and State and Territory Governments to provide continuity of support that there is considerable confusion and uncertainty about what this actually means in practice. The experience of the community managed sector is that it simply shifts the responsibility to provide support to the sector without any funding to do so. CMHA also supports the recommendation that the NDIA should report on boundary issues and that there should also be mandatory reporting by all governments on the number of people covered by disability support programs pre and post-NDIS.

In addition, the Federal Government has said that if Commonwealth mental health program clients 'choose' not to make an NDIS access request there will be no continuity of support and these people's needs will be the responsibility of state and territory governments. Where a person's 'choice' is linked to their psychosocial disability (i.e. cognitive behavioural impairments), this cost-shifting stance is of great concern and not consistent with Australia's obligations under the UN Convention on the Rights of Persons with Disability.

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Information request 5.1

Issues around state and territory costs are noted above, particularly regarding the interface between mental health and chronic illness. As noted above, the $80 million funding for people with psychosocial disability not eligible for the NDIS in the Federal Budget 2017-18 requires matched funding from the state and territories and will provide some additional funding for community based mental health services.

As noted above, there also needs to be ways of providing coordinated support to people with psychosocial disability and co-morbidity, such as chronic illness, who are NDIS participants without them having to go to more than one service system. The Federal Government and the State and Territory Governments must be able to determine with confidence where there is service crossover, and come to payment arrangements where that is required, so that NDIS participants receive the support they need through one package.

As highlighted in the PC report, the issues associated with funding supports outside of the NDIS are significant, particularly for mental health and Victoria is without exception. From July 1 2016, the Victorian Government began its progressive transferral of state funding for community mental health into the NDIS to fund disability supports. With the exception of Youth Residential Rehabilitation and Mutual Support and Self Help, there will no longer be any state-funded community support services available for people with serious mental illness. PHaMS and PIR will also progressively lose funding over the next few years, leaving clinical services as the only option for people not eligible for disability supports.

The transfer of state to federal funding and the resulting gap in community support raises the fundamental question of how will people (NDIS recipients or not) with serious mental illness in Victoria will get their psychosocial rehabilitation needs met in the future. The loss of psychosocial rehabilitation from the mental health support system will eventually impact on the wider system, including the NDIS.

Recent Victorian State Government commitments have provided some hope that people ineligible for disability supports will get some form of community mental health care. In the 2017 / 2018 State budget, the Victorian Government announced “75,000 hours of community care” to reduce the demand on clinical mental health services, following with a further investment of $20 million for community mental health in June 2017.

As more information comes to light about State and Federal priorities in the mental health space, it is apparent that the disability system, clinical system, forensic and broader health system will need to evolve and work together to best support people with mental illness. The gaps emerging as a result of the loss of the rehabilitation component will place significant strain on the health system and the burden of these gaps ultimately falls on people living with a mental illness and their families.

Market, provider and participant readiness

As raised in CMHA’s submission to the Issues Paper, a central issue is mental health not fitting into the pricing structures of the NDIS. There is an impact of the NDIS pricing structure and its relationship to qualified mental health staffing, the skills and knowledge required are different with the NDIS pricing

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structure able to fund disability support, and therefore, retaining a highly qualified mental health workforce for the NDIS is a concern.

CMHA is pleased to see the Commission acknowledge issues regarding the structure and processes of pricing and the impact this has on the market. CMHA supports the recommendation to transfer price regulation powers to an independent body by 1 July 2019. There is also an acknowledgement that there will be some markets too small to enable competitive markets. CMHA would also argue that this could also apply to highly specialised markets, and has raised the prospect of market failure in the Issues Paper submission.

An issue in the states and territories, including smaller states such as Tasmania, is that lack of attractive and competitive wages continue to impede recruitment and retention of well trained staff. The amounts set out in the NDIS Price Guide are not enough to fund complex case coordination or skilled staff particularly once expenses such as developing individual case plans and group programs, travelling time, making and following up referrals and so on have been removed.

CMHA would support a more flexible approach to funding, service delivery, and other measures for specific circumstances – as outlined in the Position Paper; and that block funding may continue to be necessary. NDIA practice that supports greater flexibility in plans would partly address issues around supporting highly complex clients within the pricing structure. This must include approaches for where people with psychosocial disability are doing well and are not doing so well (i.e., 'advance planning practices).

Building the workforce

As noted above and in CMHA's submission to the Issues Paper, an issue that has been raised by all state and territories is a high risk of seeing significant market failure across the sector. The NDIS may potentially be faced with an exponentially growing level of disability while at the same time community-based rehabilitation services are experiencing loss of funding, loss of qualified mental health staff and the capacity to provide services commensurate with need. The potential loss of existing skilled and qualified staff and a de-skilling of the workforce means that that organisations are unable to offer services to people with NDIS Plans as well as those without.

CMHA's Federal Pre-Budget Submission 2017-18[7] outlined the need to develop a National Mental Health Workforce Strategy and conduct regional Communities of Practice to support NDIS transition. A key piece of work that is required is an examination of the overall workforce in mental health to ensure there is an informed and properly planned approach to developing, supporting and maintaining the workforce to deliver the range of mental health reforms.

The lack of a comprehensive national mental health workforce strategy has been a significant policy gap. The workforce strategies that have been developed have not addressed the community managed

[7] Community Mental Health Australia 2017-18 Federal Pre-Budget Submission, http://www.treasury.gov.au/~/media/Treasury/Consultations%20and%20Reviews/Consultations/2016/2017%20PreBudget%20submissions/Submissions/PDF/Community%20Mental%20Health%20Australia.ashx

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psychosocial rehabilitation sector and has meant that reforms which have a significant impact have no guiding policy.

CMHA is pleased to see the Commission note the need for the long-term development of the workforce, but this should include the involvement of all levels of government as the Commonwealth and State and Territory Governments will be impacted by the changes to the workforce that will be brought about by the NDIS.

The CMHA NDIS Workforce Scoping paper makes seven findings and ten recommendations in relation to early identification of NDIS workforce impacts on the community managed mental health sector (see Attachment 1)[8]. Finding 1, that 'the NDIS has affected the nature of work performed' is important to the Productivity Commission's costs inquiry and Recommendation 1, to 'Undertake community mental health sector role mapping (i.e., skills, qualifications and pricing) and identify appropriate supports pricing'. This is because roles, functions and pricing for NDIS non-government psychosocial disability support services will be challenging to ascertain without consideration of the complimentary workforce contributions of public mental health and primary health care work settings. The Department of Health National Mental Health Service Planning Framework has undertaken some related workforce considerations that is not yet been publically released.

Participants need help to make the most of the NDIS

The Commission has raised the issue of assistance to NDIS participants to implement plans, including through support coordination. CMHA has made the point in a number of forums that many people, particularly people with psychosocial disability, will require support coordination over their lifetime. This may vary in the level of need, however this need will always be there. This has been a downfall of the WA NDIS, which previously only allowed for episodic coordination but has recently recognised that ongoing coordination is required and have reflected this in the price framework. At a Federal level, a balance must be struck between the expectation of the NDIS to build capacity and leaving participants without sufficient support coordination.

This is not something that has been well recognised through the NDIS and particularly through the provision of support coordination via LACs. Where it is needed, support coordination must be provided to participants, and this should be done in consultation with providers who know the participants needs. It is likely to also require a change in process for the NDIA and the LACs in recognising the centrality of this type of support, and expertise in areas such as mental health when these supports are being assessed.

The Commission in the Position Paper discusses the potential role for peer workers to assist people in navigating the NDIS. Peer workers are a central part of the community managed mental health workforce and CMHA has been raising the issue of their inclusion in an NDIS disability workforce for some time. In addition, the IAC is now developing advice e on the inclusion of peer workers in the NDIS. The NDIS currently does not adequately recognise the role or expertise of a peer workforce. CMHA

[8] Community Mental Health Australia (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project.* Sydney: Mental Health Coordinating Council.

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would support the inclusion of processes to support a peer workforce. However, peer workers should not just be restricted to intermediary or support roles – they should be able to support consistent with peer work principles and practices and be supported as part of the overall NDIS workforce and recognised as such.

Information Request 6.1

CMHA supports a more flexible approach to funding, service delivery, and other measures for specific circumstances – as outlined in the Position Paper; and that block funding may continue to be necessary. People with complex clients will benefit from strengthened approaches to flexible funding within a particular pricing structure. Ultimately, both organisations that are or were block funded are likely to either rationalise their services to those they can deliver sustainably or, if they are solely in that service market, they may indeed cease operations all together if block funding does not continue.

Feedback from CMHA members has reinforced that not all people applying for NDIS plans are successful and mental health sector in particular will benefit from block or other funding. This would allow providers to continue to provide services to these people particularly in regards to early intervention, recovery and those who are very difficult to engage.

Information Request 6.2

Particular approaches to encourage a greater supply of disability supports over the transition period could include:

- Co-operative enterprises developed and led by people with disabilities (within mental health these are often called consumer operated services and programs)
- Empowering local community driven, social enterprise based customised solutions.
- Embracing a broad diversity of supply solutions.
- Encouraging types of alternative business models to generate viable employment and business solutions for people with disability and to retain the concept of participants owning and driving their own solutions.
- Providing clear market incentives for new entrants. Businesses outside the sector, especially from sectors that provide similar supports such as health and aged care can bring their experience and learnings into the disability marketplace in many cases for the first time.
- Provide block funding to service providers to enable them to train the very low level of disability support worker so that they can provide psychosocial supports at an acceptable level, or increase the hourly rate of supports substantially to enable providers generate enough revenue to achieve the same.

Information Request 7.1

As noted above in 'Building the workforce' regarding the need to develop a National Mental Health Workforce Strategy; explore community mental health sector roles, functions and pricing; and conduct regional Communities of Practice to support NDIS transition.

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A workforce strategy should be developed to support both the mental health workforce and primary health workers, especially GPs, to prepare for mental health reforms, including the NDIS, in relation to mental health and their roles. The inclusion of the community mental health workforce is crucial. The range of reforms occurring in mental health is having an impact on the workforce in community-managed mental health sector including the pricing structures of the NDIS and the impacts on qualified staff.[9]

The workforce strategy should provide particular assistance to the consumer and carer peer workforce (both paid and volunteer), including to prepare for the NDIS. This should build the capacity of this workforce to assist consumers and carers to access the scheme productively. Along with a strategy for peer workers, key areas of need such as the Aboriginal and Torres Strait Islander, rural and remote and early childhood workforce should be a focus and part of the strategy.

The issue and implications of inadequately trained and prepared staff unable to be flexible enough, work more autonomously and commit to work at a high standard with more responsibility is at the heart of the adequacy of the workforce to deliver supports for people with psychosocial disability. The lack of suitably trained and skilled support staff this would result in less than optimal results for people with psychosocial disability.

The traditional approach of workforce development, focused on building individual capability through education and training is inadequate to meet the dynamic and changing environment of contemporary health and human services delivery. A systems-based approach to workforce planning and development is required. It involves better data collection and strategic planning to ensure that government and service providers are responding to more localised workforce challenges. It must take into account the unique issues facing rural and remote services, including the distance between communities and the complexity of health problems managed by workers practising in relative isolation. This approach also requires stronger partnerships between key stakeholders and the establishment of a closer partnership between the mental health sector and government to enable more flexibility and responsiveness in policy and funding arrangements. Closer partnership between industry and education providers will be important to better match the skills and capabilities needed in the service sector with the workforce being developed by the education sector.

Information Request 7.2

When the NDIS is well implemented respite is immediately available to families and carers through the services and supports provided to participants. However, the Federal Government decided that the Mental Health Carers: Respite Support program is in scope for the NDIS. Carers groups believe this program should not be in scope because for this program the carer is the client whereas in the NDIS, the consumer receives the funding and the carer does not. While the NDIS will benefit many people, in terms of transitioning to the Scheme, many carers will be receiving less support than they previously were. CMHA has stated support for carers should be separate to the NDIS. We also acknowledge that

[9] Community Mental Health Australia (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project.* Sydney: Mental Health Coordinating Council.

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the Department of Social Services are reviewing Federal Government carers programs outside of the NDIS, of which there will no longer be any that are mental health specific.

Information Request 8.1

Noted above in 'Participants need help to make the most of the NDIS'.

Service providers in Victoria have reported positive outcomes when Support Coordination is provided for people with psychosocial disability, particularly for those who require capacity building to help them engage with their disability supports. It is recommended that Support Coordination be offered as an ongoing line item.

The Mental Health Coordinating Council have provided the following case study with regards to participant involvement to achieve positive outcomes from the NDIS:

> Erika is an NDIS participant with psychosocial disability now on her fourth plan.[10] Erika's NDIS third plan included an aspiration to develop a 'safety' (i.e., wellbeing) plan including NDIS funded education for family and service providers to implement it. Feedback is that a 'crisis prevention' (i.e., advance planning) procedure with the local public mental health and primary care providers has now been developed and is working well.

Information Request 8.2

Noted above in 'Participants need help to make the most of the NDIS' with regards to the role of peer workers.

There are concerns that there is insufficient safeguarding in place to support participants who use intermediaries to fund non-registered services. Anecdotal evidence suggests that some providers push the boundaries in order to engage clients – providers cornering participants to use them to provide supports; agreements not being put into place.

Governance and funding

CMHA supports the recommendation of the Commission that the NDIA should adopt a process for amending or adjusting plans without triggering a full review. CMHA has previously recommended that there must be pre-planning assistance for consumers and allowing consumers to view their plan before it is finalised.

CMHA also supports the recommendation that the NDIA publicly report on reviews, including the number of reviews, review timeframes, outcomes of reviews and participant satisfaction with reviews. This has been an issue CMHA has raised significant concerns with around the number of full reviews being triggered and the time being taken for these reviews. CMHA has also raised the need for other indicators other than the number of people receiving plans, including those noted as being suggested by the Commission. In particular the need for an indicator which demonstrates consumer satisfaction with plans and the planning process.

[10] Further information on participants making the most of the NDIS is available at http://reimagine.today/step-5/thinking-about-my-plan/

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Information Request 9.1

As noted in the introduction to this submission, CMHA recognises that there are different views regarding the timeframe for rolling out the NDIS, and that people do not want to delay receiving any benefits that the NDIS can deliver. CMHA agrees that people should receive the benefits of the NDIS. We also believe that key processes should be well established and systemic problems addressed so that that people with psychosocial disability are not adversely impacted because this has not occurred. This must be taken into account in determining the timeframe for the ongoing implementation of the NDIS.

A proposal could be continuing to expand the NDIS as per the timeframe for the national roll-out, but considering a slowing down of the targets in terms of how many people to sign up in each area. It would involve resolving certain processes, for example reference packages, functional assessment tools, and expertise of planners. The sector wants to ensure we have the processes right and therefore the outcomes, even if that means taking more time.

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Attachment 1

Findings (F) and Recommendations (R) of the
CMHA NDIS Workforce Scoping Project (2015)

F1 – The NDIS has affected the nature of work performed.

R1 – Undertake community mental health sector role mapping (i.e., skills, qualifications and pricing) and identify appropriate supports pricing.

F2 – Change in work has influenced a change in skill requirements.

R2 – Make Certificate IV Mental Health and Mental Health Peer Work qualification scholarships available.

R3 – Develop on-the-job pathways to the above qualifications.

F3 – Changes to employment and deployment of workers include growing casualisation.

R4 – Identify and promote good practice deployment of staff beyond casualisation.

R5 – Identify approaches that link worker skill and consumer need levels.

R6 – Identify good practice workforce innovations and facilitate their adaption.

F4 – Organisations need more resources to understand the future impact of NDIS on the workforce.

R7 – Develop an information pack describing workforce approaches responsive to fluctuations in demand.

F5 – Quality assurance/continuous improvement processes are being challenged.

R8 – Promote quality improvement approaches to community mental health workforce effectiveness.

F6 – Focus is needed to strengthen both workforce quality and quantity.

R9 – Pursue responsive and flexible approaches to workforce innovations.

R10 – Contribute to national mental health workforce planning through use of role mapping results (R1).

F7 – Need to identify good practice community sector mental health workforce development in the NDIS environment.

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